Lifestyle HEALTH PLANS
A World of Wellness

Health Application Form

Section 1: Employer Information

Employer Name: Chestnut Holdings Hire Date: 7-24-2015
Employer Address: 5676 Riverdale Avenue Suite 307
City: BRONX State: New York Zip: 10471

Section 2: Employee Information

Employee Name: HUGGINS (Last) ALEJANDRO (First) (M.I.) Date of Birth: [redacted] 1948
Address: 1425 UNIVERSITY AV SUPER (Job Title)
BRONX (City) NY (State) 10452 (Zip)

Marital Status: ☐ Single ☐ Divorced ☒ Married ☐ Widowed
Home Phone: ( ) Cell Phone: (347) 692 5875
E-mail Address: HUGGINS0406@HOTMAIL.COM Hours Worked per Week: 40
Spouse's Employer: Spouse's Business Phone: (212) 470 9998

Section 3: Other Insurance Coverage

Are you or any dependent(s) disabled ☒ YES ☒ NO If YES, please indicate name(s):

Do you or your spouse have other health insurance? ☒ YES ☐ NO If YES, name of Carrier:
Policy Holder's Name: [redacted] Policy #: HEALTH FIRST Effective Date:
Name of Covered Dependents:

Section 4: Prior Coverage Information

To eliminate or reduce pre-existing condition waiting periods; a copy of your Certificate of Creditable Coverage from your current carrier will be required when enrollment in the program is completed. Submission of your prior coverage information does not automatically waive any pre-existing condition limitations.

Section 5: Subscriber / Dependents (Please complete for employee subscriber and all participating dependents.)

First Name	MI	Last Name	Social Security #	DOB	Age	M / F	Tobacco Use YES / NO
ANA	M	HUGGINS	[redacted] 8927	[redacted] 1960		F	NO

Section 6: Health Plan Enrollment

☒ I elect to participate
☒ I decline participation

Coverage Level
☐ Employee Only
☐ Employee / Spouse
☐ Employee / Child(ren)
☐ Family

Plan Selected
Options provided upon underwriting approval

Section 7: Health Information

Please furnish us with the height and weight or you and your spouse:

[redacted]